

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/18/2013  
FORM APPROVED  
OMB NO. 0938-0391

45th 8/30/13

STATEMENT OF DEFICIENCIES  
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA  
IDENTIFICATION NUMBER:

445473

(X2) MULTIPLE CONSTRUCTION  
A. BUILDING 01 - MAIN BUILDING 01

B. WING

(X3) DATE SURVEY  
COMPLETED

07/14/2013

NAME OF PROVIDER OR SUPPLIER

JEFFERSON COUNTY NURSING HOME

STREET ADDRESS, CITY, STATE, ZIP CODE

914 INDUSTRIAL PARK RD  
DANDRIDGE, TN 37725

(X4) ID  
PREFIX  
TAG

SUMMARY STATEMENT OF DEFICIENCIES  
(EACH DEFICIENCY MUST BE PRECEDED BY FULL  
REGULATORY OR LSC IDENTIFYING INFORMATION)

ID  
PREFIX  
TAG

PROVIDER'S PLAN OF CORRECTION  
(EACH CORRECTIVE ACTION SHOULD BE  
CROSS-REFERENCED TO THE APPROPRIATE  
DEFICIENCY)

(X5)  
COMPLETION  
DATE

K 018  
SS=D

NFPA 101 LIFE SAFETY CODE STANDARD

Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 1/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3

Roller latches are prohibited by CMS regulations in all health care facilities.

This STANDARD is not met as evidenced by:  
Based on observation, the facility failed to ensure corridor doors were smoke resistant.

The findings include:

Observation on July 14, 2013 at 11:50 a.m. revealed that the janitors' closet by the front entrance nurses' station has a louvered door.

This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference.

K 038

NFPA 101 LIFE SAFETY CODE STANDARD

K 018

The janitor's closet by the front entrance nurses' station with the louvered door will be modified in order to achieve the fire rating required by code.

All other doors will be assessed and any identified with louvers will be modified for same non-compliant characteristic. This requirement and corrective action will be discussed in the facility's Quality Assurance Performance Improvement meeting which will be held on Friday, July 26, 2013.

Once modified, door will be assessed by Maintenance Director and visually inspected for compliance by the Administrator.

08/23/2013

K 038

Delayed egress signage will be placed on  
(continued on next page)

08/23/2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Roger L. Mynatt

TITLE

Administrator

(X6) DATE

7/31/13

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER  JEFFERSON COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 914 INDUSTRIAL PARK RD DANDRIDGE, TN 37725		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 038 SS=D	Continued From page 1  Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure delayed egress doors had appropriate signage.  The findings include:  Observation with the maintenance director on July 14, 2013 from 10:45 a.m. and 12:00 p.m. revealed that the facility failed to have delayed egress signage on the following doors: 1. Front entrance door. 2. Kitchen service hall exit door.  These findings were verified by the maintenance director and acknowledged by the administrator during the exit conference on July 14, 2013. NFPA 101 LIFE SAFETY CODE STANDARD	K 038	(continued from previous page) the front entrance door and the kitchen service hall exit door of the main building.  All other doors in the main building requiring delayed egress signage will be identified and have signage added. This requirement and corrective action will be discussed in the facility's Quality Assurance Performance Improvement meeting which will be held on Friday, July 26, 2013.  Once installed, signage will be assessed by Maintenance Director and visually inspected for compliance by the Administrator.		
K 045 SS=F	Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8  This STANDARD is not met as evidenced by:	K 045	In Main Building 1, exit discharges by room 416, 400 and at the vending machines will have additional independent lighting added in order to ensure that the failure of a single lighting fixture will not leave the area identified in total darkness.  All other exits in Main Building 1 will be assessed to determine if additional independent lighting fixtures need to be added in order to ensure that the failure of a (continued on next page)	08/23/2013	

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NAME OF PROVIDER OR SUPPLIER  JEFFERSON COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 214 INDUSTRIAL PARK RD DANDRIDGE, TN 37725		
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K 045	Continued From page 2 Based on observation, the facility failed to have exit paths lighted so the area would not be in total darkness.  The findings include:  Observation on July 14, 2013 from 11:00 a.m. and 11:30 a.m. revealed the following locations did not have exit discharge arranged so that the failure of any single lighting fixture (bulb) will not leave the area in total darkness. 1. Exit discharge by room 416. 2. Exit discharge by room 400. 3. Exit discharge by vending machines.  These findings were verified by the maintenance director and acknowledged by the administrator during the exit conference on July 14, 2013. NFPA 101 LIFE SAFETY CODE STANDARD	K 045	(continued from previous page) single lighting fixture will not leave the area identified in total darkness.  Once additional lighting is added, the light fixtures will be assessed by the Maintenance Director and visually inspected for compliance by the Administrator. This requirement and corrective action will be discussed in the facility's Quality Assurance Performance Improvement meeting which will be held on Friday, July 26, 2013		
K 066 SS=D	Smoking regulations are adopted and include no less than the following provisions:  (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.  (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.  (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.	K 066	In the main building, designated smoking areas will have metal containers with self-closing cover devices into which ashtrays can be emptied into.  Other areas in the main building designated as smoking areas will have metal containers with self closing cover devices into which ashtrays can be emptied into.  The presence of such ashtrays will be monitored by the Housekeeping and Laundry Supervisor on an on-going basis. This requirement and corrective action will be discussed in the facility's Quality Assurance Performance Improvement meeting which will be held on Friday, July 26, 2013.  (continued on next page)	08/23/2013	

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K 066	<p>Continued From page 3</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>This STANDARD is not met as evidenced by: Based on observation, the facility failed to provide appropriate ashtray containers in designated smoking areas.</p> <p>The findings include:</p> <p>Observation on July 14, 2013 at 2:00 p.m. revealed that the facility's designated smoking areas did not have metal containers with self-closing cover devices into which ashtrays can be emptied into.</p> <p>This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on July 14, 2013</p>	K 066	(continued from previous page) Compliance of the verification that the ashtrays are present will be made by the Administrator.		